

# In the best interests of society

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Each year, exposure to violent trauma takes its toll on the development of millions of children. When their trauma goes unaddressed, children are at greater risk for school failure; anxiety and depression and other post-traumatic disorders; alcohol and drug abuse, and, later in life, engaging in violence similar to that to which they were originally exposed. In spite of the serious psychiatric/developmental sequelae of violence exposure, the majority of severely and chronically traumatized children and youth are not found in mental health clinics. Instead, they typically are seen as the 'trouble-children' in schools or emerge in the child protective, law enforcement, substance abuse treatment, and criminal justice systems, where the root of their problems in exposure to violence and abuse is typically not identified or addressed. Usually, providers in all of these diverse service systems have not been sufficiently trained to know and identify the traumatic origins of the children's presenting difficulties and are not sufficiently equipped to assist with their remediation. This multiplicity of traumatic manifestations outside the mental health setting leads to the inescapable conclusion that we are dealing with a supra-clinical problem that can only be resolved by going beyond the child's individual clinical needs to enlist a range of coordinated services for the child and the family. This paper will focus on domestic violence as a paradigmatic source of violent traumatization and will (a) describe the impact and consequences of exposure to violence on children's immediate and long-term development; (b) examine the opportunities for, as well as the barriers to, bridging the clinical phenomena of children's violent trauma and the existing systems of care that might best meet their needs; and (c) critique current national policies that militate against a more rational and coherent approach to addressing these needs. **Keywords:** Child witness, parent-child relationships, public health, risk factors, service development, trauma.

An impressive body of knowledge has emerged over the last two decades on the impact of childhood trauma. There is now incontrovertible evidence that children's responses to trauma can render them simultaneously over-reactive, helpless and immobilized – whether as victims of abuse, witnesses to domestic and community violence, or survivors of natural and man-made disasters. The experience of overwhelming and often unanticipated danger triggers a traumatic dysregulation of neurobiological, cognitive, social and affective processes that has different behavioral manifestations depending on the child's developmental stage, but is usually expressed through problems of relating and learning in the forms of aggression, hyperarousal, emotional withdrawal, attentional problems, and psychiatric disturbances (Pynoos, Steinberg, & Piacentini, 1999; van der Kolk, 2003). These problems can have an enduring impact on development and may substantially alter a child's biological makeup through long-lasting changes in brain anatomy and physiology, particularly when the traumatic circumstances are chronic and sources of support are inadequate (Carrión, 2006; DeBellis et al., 1999a, 1999b). As a result, the unaddressed consequences of trauma not only have an adverse impact on individual children throughout their lives, but also affect the lives of those around them and can ultimately mar the healthy development of their own children.

The majority of severely and chronically traumatized children and youth are not found in mental health clinics but in the child protective, law enforcement, substance abuse treatment, and criminal justice systems, where the root of their problems in exposure to violence and abuse is typically not identified or addressed. Before reaching these systems, traumatized children are often identified and/or mislabeled as 'behavior and discipline problems' in childcare and school settings, where their maltreatment is also routinely unrecognized. Providers in all of these diverse service systems have not been sufficiently trained to know and identify the traumatic origins of the children's presenting difficulties and are not sufficiently equipped to assist with their remediation. In addition, given the way these systems are currently organized, it is almost axiomatic that each system works mostly from within its own isolated silo and is unable as a result to construct a comprehensive picture of the range of problems afflicting the child. Without such a picture, service providers can, at best, attempt to meet the child's needs from the sole perspective and circumscribed resources of their own agencies, but are not equipped to coordinate their responses across the other systems that must be involved to address the full spectrum of the child's needs. Although laudable efforts are being made to promote coordination across systems – for example, through Safe Start (Kracke, 2001), the Green Book Initiative (Caliber

Assoc. et al., 2004) and Systems of Care (Center for Mental Health Services, 2001) – there is inconsistent attention to the organizing role of child trauma in the problems presented by children across the different systems.

The recognition of the long-lasting and pervasive consequences of unaddressed trauma demands that we optimize access to services and raise the quality of care for traumatized children and their families. This can be achieved through a better coordination among the settings in which they are most likely to present – first as children and later as adults and parents who are bearing the consequences of their earlier traumatic experiences. Understanding the context of childhood trauma makes clear that addressing the needs of traumatized children must entail attention to the child, the family, and the environment in which they live. This ecological-transactional approach, although long recommended (Bronfenbrenner, 1979, 1986; Cicchetti & Lynch, 1993), is seldom implemented. The psychiatric and behavioral manifestations of traumatic stress are so compelling that there is an understandable but ultimately misguided tendency to treat child trauma only as a clinical phenomenon that must be addressed with the tools of the mental health field. This narrow focus must be superseded by the ubiquity of trauma as the frequent cause of physical and mental illness, school underachievement and failure, substance abuse, maltreatment, and criminal behavior. This multiplicity of traumatic manifestations outside the mental health setting leads to the inescapable conclusion that we are dealing with a supra-clinical problem that can only be resolved by going beyond the child's individual clinical needs to enlist a range of coordinated services for the child and the family.

The purpose of this paper is to use the background sketched above for the following purposes: (a) elucidate the impact and consequences of exposure to violence on children's immediate and long-term development; (b) examine barriers and opportunities to 'connecting the dots' between the clinical phenomena of children's violence-related trauma and the existing systems of care that might best meet their needs; and (c) critique current national policies that appear to militate against a more rational and coherent approach. We will focus on domestic violence as a paradigmatic and often unacknowledged source of childhood trauma because of the well-established overlap between child exposure to domestic violence and other forms of child maltreatment. While the impact of violent trauma on children's development is perhaps of international concern and the barriers, as well as opportunities, for addressing the needs of traumatized children may be similar, this paper will address these issues primarily from the perspective of current circumstances in the United States.

## Background and scope of child trauma

The role of trauma in child development has long been central in specialized fields of study and clinical care. Starting with the early clinical observations and conceptual work of Freud (1926), the plight of children in adverse circumstances has been documented through observations of children in wartime (A. Freud & D. Burlingham, 1954; A. Freud & Dann, 1949); institutional care (Spitz, 1945; Provence & Lipton, 1962); separations occurring as a result of hospitalization (Robertson, 1958; Jackson, 1942); harsh and punitive parenting (Fraiberg, Adelson, & Shapiro, 1975; Fraiberg, 1980); foster care and custody conflicts (Goldstein, Freud, & Solnit, 1973); and school settings (Comer, 1980). Each of these early contributions has led to a greater appreciation of the unique, developmentally determined psychological needs of children confronted with adverse conditions. The findings spurred a change in practices in a limited range of settings, but these changes have never been applied in a scale that reflects the sheer volume of children affected by the adverse conditions they attempt to address.

The developmental perspective taken by these pioneering contributors set the stage for the recent expansion in the scope of inquiry to include a broader range of sources of childhood trauma, such as natural and man-made disasters; community and domestic violence; sudden and dramatic experiences of bodily injury and insult; and witnessing the traumatic death of a parent (e.g., Cicchetti & Lynch, 1993; Pynoos, 1993; Terr, 1991; van der Kolk, 1996). This broader focus converged with the dramatic explosion of community violence in the late 1980s and 1990s that continues to affect far too many of our nation's children (Lynch, 2006). The cumulative impact of these events can derail multiple domains of the child's functioning, constituting what is sometimes referred to as 'developmental trauma disorder' (Cook et al., 2005; Pynoos et al., 1999).

There are striking parallels between our emerging appreciation of the role of child exposure to multiple sources of traumatic violence and the 'discovery' of the battered child syndrome over forty years ago. As Melton (2005) tells it, Henry Kempe and his colleagues reported in 1962 the discovery of the battered child syndrome and concluded that 'child maltreatment in the United States was a problem annually affecting a few hundred children subjected to the violent behavior of some seriously disturbed parents.' Since this pioneering work, epidemiological studies (see below) have revealed that the incidence of childhood maltreatment and trauma is much greater than Kempe and colleagues imagined, affecting millions of children. Similarly, there is now a consensus that the number of children exposed to the additional traumatic stressors of exposure to community and domestic violence, kidnappings,

natural and man-made disasters, and involvement in emergency medical settings is much greater than initially thought (Feerick & Silverman, 2006; Laor & Wolmer, 2003).

The emerging data led some observers to characterize childhood trauma as an urgent public health problem (van der Kolk, 2005; Harris, Putnam, & Fairbank, 2005; Sharfstein, 2006). The gravity of the situation is underscored by advances in brain imaging techniques that are yielding sobering findings about the long-term impact of chronic traumatic events on brain anatomy and physiology, including lasting alterations in the HPA system (hypothalamic-pituitary-adrenal axis) and the norepinephrine systems, as well as dysregulation in the prefrontal cortex, hippocampus, and amygdala (Bremner, 2003).

In response to the convergence of data about children's trauma risk, the Surgeon General of the United States convened a workshop in March 2005 entitled 'Making Prevention of Child Maltreatment a National Priority: Implementing Innovations of a Public Health Approach.' Similarly, Steven Sharfstein (2006), in announcing the formation of an American Psychiatric Association task force on the effects of violence on children, stated that 'Interpersonal violence, especially violence experienced by children, is the largest single preventable cause of mental illness. What cigarette smoking is to the rest of medicine, early childhood violence is to psychiatry.'

The numbers of children at risk for serious trauma are alarming. Child abuse and neglect cases are substantiated at the rate of 1 million per year, with 3 million yearly reports (USDHHS, 2005). At least one traumatic event was experienced by 64% of children in grades 4 through 12 in NYC *prior to* the September 11, 2001 attacks on the World Trade Centers (Hoven et al., 2002). More than 500,000 children are placed in the foster care system each year (Administration for Children and Families, 2005). Of these, 48% have been placed due to physical abuse and 45% due to sexual abuse (Dwyer & Noonan, 2001). The long-term effects are evident in reports that nearly two-thirds of people in drug treatment programs reported being abused as children (Swan, 1998). Sexual abuse has been reported by 62% of teenage mothers, and traumatic childhood events are documented in the histories of as much as 98.6% of juvenile delinquents (Carrion & Steiner, 2000).

Abuse, neglect, and exposure to violence affect not only emotional wellbeing and behavior but have long-term repercussions on physical health as well. In the Adverse Childhood Experiences (ACE) study of over 13,000 enrollees in Kaiser Permanente health insurance plans, a host of challenging childhood events emerged as the most significant predictors of adult ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease (Felitti et al., 1998). These rank among the leading causes of death in adulthood. ACE researchers also found

that the nine categories of traumatic childhood events – psychological, physical and sexual abuse; violence against the mother, living as a child with a household member who abused substances, was suicidal or mentally ill, or was ever imprisoned; absence of one or both parents; and physical or emotional neglect – exhibited a highly statistically significant graded relationship to each of the adult health risk behaviors and diseases that was examined. For example, compared to individuals who had not experienced any of the nine adverse childhood events, respondents who had experienced four or more of these adversities had a 4- to 12-fold increased likelihood of alcoholism, drug abuse, depression and suicide attempts and a 2- to 4-fold increased likelihood of smoking (including smoking by age 14 and chronic smoking as adults) and sexually transmitted diseases.

The authors of the ACE study posit that health-risk behaviors may serve as mediators between traumatic childhood events and the development of adult disease years later because the trauma-exposed may turn to chronic smoking, drug, or alcohol use to cope with anxiety, depression, and anger (Felitti et al., 1998). The ACE studies and related research make it manifestly clear that child maltreatment, family violence, and malfunction exact enormous mental, physical and social costs over an individual's life. In aggregate, these costs may represent the single largest public health problem in the United States, as explicated in the following citation: 'Writing in the April 22, 2005 *Science*, Frank Putnam and colleagues summarized the estimated prevalence of childhood sexual abuse and the association between childhood sexual abuse and serious mental and physical health problems, including substance abuse and criminality in adulthood. It is estimated that more than one third of the U.S. population may have suffered a serious interpersonal trauma such as crime victimization, physical or sexual abuse, or assault. As much as 15 percent of the general population may have suffered multiple traumatic violent events frequently beginning in early childhood. High-risk groups, such as inner-city youth, have even higher rates of trauma related to poverty, frequent violent crime, family dysfunction, and pervasive substance abuse' (Sharfstein, 2006). In a draft report of the APA Task Force on the Biopsychosocial Consequences of Childhood Violence, the authors note that in the ACE studies every traumatic event is counted only once, although it is likely to have occurred repeatedly and to have interactive effects in combination with other traumatic events, greatly increasing the magnitude of their damaging impact.'

The consequences of chronic childhood trauma are inextricably linked to the toxic effects of long-term and pervasive poverty. This overlap is illustrated by the stark differences in the prevalence of domestic violence among different socioeconomic groups. A Department of Justice report shows that

the likelihood of domestic violence increases as family income decreases (U.S. Dept of Justice, 1998). The incidence of domestic violence is 3% for families earning more than \$75,000/year, and rises to 20% for families with a yearly income of less than \$7,500. Poverty, in turn, is associated with racial and ethnic minority status. Minority children are not only more likely to be poor, but they are also more vulnerable to the impact of traumatic events due to the cumulative effects of more negative circumstances and less access to services (Supplement to the United States Surgeon General Report, 2001). They are more likely to be placed in foster care following a report of child abuse or neglect, are kept out of their homes for longer periods, endure more changes in foster care placement, and are less likely to be reunified with their families of origin (Casey Family Fund Website, Programs Child Welfare Fact Sheet, 2005). Moreover, while approximately half of these children have a diagnosed mental health need, 75% of these diagnosed children did not receive mental health treatment within twelve months of a child abuse or neglect investigation (Burns et al., 2004). Even accounting for differential likelihood and reporting, these statistics highlight the corrosive impact of poverty and racial and ethnic biases that make poor and minority children bear a disproportionate portion of the burden of early trauma and its sequelae.

While the statistics are both impressive and disturbing, meeting a single child who has suffered the cumulative impact of trauma from multiple sources helps to illustrate the price paid, both by the child and society, when significant developmental insults go unrecognized and unattended.

### *The story of Andre*

In 1991, a Yale Child Study Center clinician was called by medical staff on the surgical ward of the hospital to consult about a 15-year-old boy who had been shot twice in the upper thighs by rival drug dealers. The boy's friend lay in a coma in the ICU with what would prove to be fatal gunshot wounds to the chest and head. The fifteen-year-old, Andre, was medically stable but uncooperative with staff. He alternated between screaming tirades and sullen withdrawal. He stared into space for hours, and ignored attempts by hospital staff to engage him in discussion about his condition or about the events that led to his injuries. When the Child Study Center clinician arrived on the floor, hospital staff described Andre both as scary and as a 'pain in the ass'.

After the clinician introduced himself, Andre's deadened stare shifted and he sneered, briefly revealing a full set of gold-capped teeth with the initials 'RIP' (Rest in Peace) stenciled on the upper caps and his initials in the lower set. He then angrily demanded a second line to his phone so that he could keep up with the incessant beeping from his pager. The boy's presentation quickly led the mental

health consultant to appreciate the response of the hospital staff towards Andre.

What emerged in discussions between the clinician and Andre's mother and, subsequently, with his public defender, was the story of a boy who had had multiple contacts with medical and social services, the police, and the courts throughout his life. A long history of trauma and developmental difficulties had begun with the diagnosis of a malignant tumor at age 2, followed by several years of medical treatment that included chemotherapy and radiation. In addition, Andre's father, a mainline heroin addict, moved dramatically in and out of his son's life, seeming only to appear at home when he was desperate for a place to sleep or to steal from his family to maintain his drug habit. The father's visits were typically volatile and often ended with his beating Andre, Andre's mother, or both.

Andre's mother suffered chronic, untreated depression and had difficulties sustaining employment. Housing was never permanent, and frequent moves within and between towns coincided first with Andre's declining abilities in school and finally with his persistent truancy. Andre was new to New Haven, but with two recent arrests for street-level drug dealing, he was becoming known to the police and juvenile courts there. In fact, at the time of the shooting, Andre was being prosecuted for possession and drug dealing after having failed to complete an outpatient substance abuse program. His next court date was to be in six weeks.

Andre voiced a desire to seek revenge for the shooting, which only intensified with the death of his friend. After this death, he suffered an acute psychotic episode. Transferred from the surgical ward to a psychiatric unit for several days until his psychosis cleared, Andre was discharged before treatment was completed and before a meaningful transition plan could be put into place. Before appearing in court four weeks after the shooting, Andre was admitted twice to emergency rooms in another town with PCP psychosis. Subsequently arrested on drug dealing and weapons charges, he was adjudicated to the state juvenile corrections facility for eighteen months.

In this case, the very late introduction of a mental health consultation could offer little to counter Andre's long history of traumatic derailment and the developmental psychopathology that ensued. After leaving the juvenile correction facility, Andre returned to the streets, where he rejoined the legions of young men who also seek to undo the cumulative effects of traumatic helplessness through the sense of potency found in drug deals, guns and violence.

We may wring our hands about the price the community pays for Andre's psychopathology, and we may point fingers about the missed opportunities to intervene earlier at any of the multiple chances to do so before Andre's traumatic derailment was complete. Where, we might ask, were the behavioral

health interventions that might have accompanied his early medical treatments? Andre's teeth, bearing the signal of 'RIP', graphically demonstrated the unconscious or perhaps conscious conviction that he would die. We can interpret this display as an effort to exert mastery over his fate by converting the terrifying passivity of his traumatic exposure to intrusive medical procedures as a toddler and his helplessness in the face of the chronically traumatic instability of his daily life into his active risk-taking behavior and his habitual inflicting of pain and terror on others as an adolescent.

At the more concrete level of promoting safety, where were opportunities missed for police intervention to keep this boy and his mother safe from repeated episodes of domestic violence? And where was the recognition of the traumatic impact of that violence on both mother and son and the interventions that might have ameliorated them? Where were the schools, social services, and courts in investigating the behavioral health underpinnings of Andre's academic and social failure? Where was the acknowledgement that unstable housing would further destabilize such a fragile family? And where was the recognition that the traumatic experiences and chronic depression of the mother might seriously impair not only her capacity to look after herself, but also to minister to the needs of her child? And when we stop pointing fingers, we might also ask: How could we expect more of police, social services, housing agencies, schools, medical providers and the criminal justice system when they are ill-equipped and untrained to appreciate the developmental meaning, signs and symptoms of traumatic experience, and woefully lacking in the resources to address them even if they did?

These questions highlight again the supra-clinical nature of the interventions that are needed to address the sequelae of multiple trauma in the context of poverty and multi-generational failures of healthy adaptation. The training of mental health providers and the structure of medical and mental health institutions may predispose towards a solely clinical bias in choosing interventions that may address Andre's needs, but clinical experience also teaches us that mental health intervention, while necessary, is not sufficient to help Andre. Safe neighborhoods, appropriate housing, adequate sources of employment and family support, remedial education, external limits and consequences, and reliable access to medical care need to form the backdrop for any mental health intervention that would otherwise be ineffective on its own. Unfortunately, responsibility for traumatized children is spread around a large number of federal, state and local agencies. The result is a systemic incoherence where no single person or agency is responsible for the coordination of services for a child. For example, we have repeatedly encountered circumstances where a child welfare worker changes a child's foster placement

without notifying either the child's attorney or therapist. Thus, the opportunity is lost to help the child anticipate and process an abrupt change that, with its resemblance to the earlier removal from his or her biological parents, may serve as a traumatic reminder that triggers an aggressive response that may be destructive to the self or others. The disconnection between the dots represented by local, state and federal agencies is not only an absence of effective action – it results in an actively harmful and re-traumatizing environment for the child and, as in the case of Andre, the toxic impact of the child's symptomatology on the broader community as well.

### **Looking through the trauma lens**

We propose that using a trauma lens as a systematic point of view for understanding the needs of children and families exposed to violence can have a unifying effect across service providers. This shared point of view has the potential to increase the awareness of childhood trauma among service providers in those systems most likely to come into contact with traumatized children and their families and increase recognition of the potentially constructive roles that each agency/provider can play. These roles include ameliorating trauma by re-establishing safety; providing for basic needs; aiding families in returning to basic routines of daily life; recognizing symptoms of traumatic dysregulation; and making appropriate referrals for additional services. If police, emergency response staff, pediatric care providers, teachers, child welfare workers, attorneys and judges understood the underpinnings of child traumatic responses, they could join forces in creating conditions that would help to alleviate traumatic sequelae and support developmental progress. The example of domestic violence is used in the section below to illustrate the prevailing failures to take coordinated action across systems to connect the disparate dots of inter-agency intervention.

### **The paradigm of domestic violence**

We know a great deal about the numbers and the impact on women and children of being caught up in the fear and oppression of domestic violence. Studies over the past 22 years have estimated that domestic violence is witnessed by 3–10 million children each year (Carlson, 1984; Carter, Weithorn, & Behrman, 1999; Silvern et al., 1995; Straus & Gelles, 1990). A more recent study indicates that the number of children annually exposed to domestic violence is closer to 15.5 million; including 7 million children who are exposed to violence in the home characterized as 'severe' (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). Children who have been exposed to domestic violence are 158% more likely to be victimized by violence themselves than

counterparts from non-violent households – the risk was 115% higher for boys and 229% higher for girls (Mitchell & Finkelhor, 2001). For example, 60–75% of families where there is domestic violence also have children who are battered (Osofsky, 1999; McKibben, DeVos, & Newberger, 1989). Battered women are more likely to abuse their children more than non-battered women (Straus & Gelles, 1990; Ross, 1996). Exposure to domestic violence in childhood is associated with increased likelihood of involvement in physical aggression, delinquent and violent behaviors (Jenkins & Bell, 1997; Thornberry, 1994; Shakoor & Chalmers, 1991). Children exposed to domestic violence are more prone to depressive symptoms than those not exposed (Sternberg et al., 1993). Annual costs to US businesses in lost work time, increased health care costs, higher turnover and lower productivity is about \$5–10 billion (National Center for Injury Prevention and Control, 2003).

Considering the above statistics in the case of one urban community gives us a sobering view of the complexity, and detail, of the problem. Even in a small city like New Haven, with a population of 125,000, the problem of domestic violence is staggering. In 2005, there were 2,110 police-involved cases of domestic violence. In addition to referral to court-based domestic violence, roughly 25% of these families were referred to an agency that specializes in helping to arrange for concrete needs (e.g., food, housing, employment, etc.). In the police-involved cases, 862 children were on the scene; 789 referrals were made to the Domestic Violence Home-Visit Intervention Project (DV-HVIP) (described below). Approximately 100 women and children were provided emergency shelter; 58 women were seen in support groups; approximately 40 women were seen for individual psychological treatment as a result of referrals following incidents of domestic violence.

These figures show that to the extent that the women received any services at all beyond their initial police contact, in the vast majority of cases neither they nor their children became involved in the wide range of available and necessary services, including mental health care. There are considerable and very real barriers to women receiving clinical mental health and other services: stigma, poverty, financial insecurity, inadequate housing, scarcity of jobs, and lack of reliable and affordable childcare needed to take on regular employment. These factors may also stand in the way of a battered woman's readiness to move herself and her children away from a perpetrator on whom she may depend for the most basic physical and emotional needs. Equally substantial obstacles include fear and intimidation that induce immobilizing terror and depression. An overarching but seldom recognized obstacle to change is the hope that the love and security that were associated with the perpetrator at some point in the relationship will reassert itself and will lead to a

permanent and harmonious reconciliation. Last but not least, her children's longing for the intermittently loving and violent partner may serve as a powerful disincentive for the battered woman's motivation to leave.

Looking through the trauma lens helps us recognize the critical factors and overwhelming burdens associated with domestic violence. This recognition serves as the basis for addressing the most immediate needs of battered women and children and for establishing the first and most crucial therapeutic set of interventions: the provision of food, shelter, clothing and safety. They are absolutely central to the therapeutic tasks of aiding the recovery of both battered mothers and their children because they help restore a sense of agency and psychological order. These needs continue after the women complete their allotted time in a battered women's shelter and are required to leave, often before a stable housing environment is provided for them. Providing therapeutic intervention, while aiding their recovery from trauma, is insufficient if the family's concrete needs are not adequately met.

Safety is a basic requirement for recovery from trauma. Parents and children cannot decrease their level of hyper-vigilance when the anticipation of violence is real and immediate. While it is absolutely essential to provide for the safety of each family member, doing so often presents daunting challenges. Traditionally, contact between police and the affected families is initiated by acute episodes of domestic violence. The police intervention typically stops the immediate violence, often leading to the arrest of the assailant (or dual arrests of both partners involved in the altercation), coordination with emergency medical services and, at times, the engagement of child protective services.

For the police, responding to domestic violence incidents presents one of the greatest risks for being assaulted in the line of duty (Mayhew, 2001; Hirschel, Dean, & Lumb, 1994). These calls are also a source of great frustration, especially when repeat visits to the same addresses confirm police officers' experiences of how very limited their interventions are in stopping the brutal behaviors involved in domestic violence. It is not surprising that police attention to the psychological status of battered women and their children may be limited by these circumstances and by the sheer volume of additional calls to which they must respond on any given shift.

From the perspective of the battered woman, the police presence may represent immediate safety, but it may equally be a barometer of her shame and humiliation as well. The police response may also present a direct threat to the integrity of her family, because of the removal of the violent partner as well as the possible removal of her children. The children, for their part, may experience a similar relief that police have stopped the screaming and beating, but may view the police in a much more negative and

frightening light when they arrest one or both parents or initiate their removal from a dangerous, but familiar home.

Programs addressing domestic violence must make an effort to incorporate the various facets of this complex picture into their intervention. Two programs are described below as examples of the effort to do so.

### **Efforts to connect the dots: programmatic illustrations**

Throughout the country, many programs have been developed with the aim of coordinating services across different service systems on behalf of traumatized children.

Some of these programs exist within service systems outside of the mental health paradigm. The Boston Medical Center Department of Pediatrics, for example, has developed an innovative model integration that focuses on low-income children and their families and involves pediatrics, mental health, and the law to advocate for the child's physical, mental, and environmental wellbeing. Pediatric providers work in coordination with mental health providers and with attorneys to protect the totality of the child's health by addressing physical problems, emotional distress, and enlisting the power of the law to motivate landlords to improve housing conditions that are conducive to health problems such as asthma. Two child mental health programs that collaborate with other service systems on behalf of traumatized children are described below.

*New Haven Child Development-Community Policing (CD-CP) Program.* As part of the National Center for Children Exposed to Violence at the Yale Child Study Center, this program is a collaboration of mental health, law enforcement, juvenile justice, education, judicial and social service professionals, working together to respond in a coordinated fashion to children and families who have been exposed to violence. A central element of the program is the recognition of the important stabilizing role that police can play in the lives of children and families at times of crisis, and its integration of law enforcement and mental health principles in an interdisciplinary intervention.

The core components of the program are *cross training* in principles of child development, trauma, and policing for the professionals involved in the program; the *Acute Response Service*, staffed by mental health professionals on call 24 hours a day, seven days a week, to respond immediately to police calls involving child victims or witnesses to violence; the *Childhood Trauma Clinic*, which provides trauma assessment and trauma-focused treatment to children and families following their referral to the acute response service; and the *Domestic Violence Home Visit Intervention Project (DV-HVIP)*, which provides

follow-up home visits to children and families affected by domestic violence (Marans & Berkman, 2006; Berkman, Casey, Berkowitz, & Marans, 2004).

The *Domestic Violence Home-Visiting Intervention (DV-HVIP)* grew out of the fact that 30–40% of all police calls for service and of the CD-CP Acute Response Service in New Haven involved domestic violence, with a disproportionate number of exposed children under the age of five. The *DV-HVIP* also reflected the special circumstances of affected children who require help that must begin with the restoration of safety at home and support for mothers who are the foundation for their recovery.

Begun in 2001, the *DV-HVIP* is implemented by a team of highly-trained police patrol officers, community outreach advocates, and child mental health professionals that provides information, support, comprehensive social services, enhanced law enforcement, and access to clinical treatment to children and families. The home visit intervention project is currently implemented in five of New Haven's ten policing districts. Police officers participating in the project are community-based officers regularly assigned to the neighborhood where the follow-up visits are taking place and who are familiar with neighborhood residents, issues, and resources. Patrol officers are paired with advocates who are trained in basic domestic violence issues, crisis intervention and child development principles; are familiar with local domestic violence law, criminal justice processes and social service resources; and who are supervised by senior clinicians at the CD-CP Program. Follow-up home visits are intended to monitor victim safety; improve victims' understanding and enforcement of court orders (e.g., restraining orders); increase access to information and concrete services (911 phones, locks changed, shelters, food assistance); and provide psychological support and access to treatment for victims and their children.

The experience of the *Domestic Violence Home Visit Intervention Project* has shown that many women who might decline legal or mental health services for themselves are more easily engaged in increasing their own safety when they are approached with a focus on their children's needs. Typically, the *DV-HVIP* team concentrates first on issues of physical safety, acute mental health assessment and practical support. A wide range of mental health treatments for children and families are available through the Childhood Trauma Clinic once a family's environment is more stable. While there are promising indications that the *DV-HVIP* approach is beneficial to the families, police officers, advocates, and mental health professionals engaged in it, there are, as yet, insufficient funds to make the practices available to the whole city of New Haven or to begin piloting the initiative in other cities.

*Child Trauma Research Project (CTR)* is a program of the University of California San Francisco located at San Francisco General Hospital in the Mission

district, a neighborhood historically populated by low-income and working class immigrant families and currently a predominantly Latino area. CTRP has developed an approach to intervention with children in the birth-to-five age range in which mental health treatment is integrated with other service systems considered relevant to the wellbeing of the child and the family. The treatment, known as Child-Parent Psychotherapy (CPP), consists of joint sessions with the young child and one or both parents that promote the child's mental health by fostering pleasurable and developmentally appropriate child-parent interactions and targeting for change punitive, neglecting, or otherwise maladaptive parenting practices (Lieberman & Van Horn, 2005; Lieberman, Padron, Van Horn, & Harris, 2005). CPP has shown empirical evidence of efficacy in four randomized controlled studies with underserved multicultural populations, including unacculturated Latino mother-toddler dyads, toddlers of depressed mothers, maltreated preschoolers in the child protective system, and preschoolers exposed to domestic violence (Cicchetti, Rogosh, & Toth, 2000; Cicchetti, Toth, & Rogosh, 1999; Lieberman, Weston, & Pawl, 1991; Lieberman, Van Horn, & Ghosh Ippen, 2005; Lieberman, Ghosh Ippen, & Van Horn, 2006; Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002).

Referrals come from community agencies and service providers, including childcare programs, family resource centers, pediatric providers, battered women's shelters, and the legal system. Issues of confidentiality and often conflicting expectations can strain collaboration between mental health providers and the legal system, but in spite of these challenges the CTRP experience has been that collaboration among the clinician, the courts and the child protective system can be a valuable vehicle to achieving treatment goals. Specifically, when the parent is unable to make sufficient use of treatment to curb the destructive impact of family violence on the child's wellbeing, the involvement of external sources of control, in the forms of the child protective services and the legal system, can have a modulating effect on the parent's dysregulated and punitive behavior.

The question of who may safely participate in the treatment needs careful evaluation. The literature on marital therapy indicates that couples' treatment may be hazardous when there is domestic violence because the therapeutic situation may generate a false sense of safety, leading to disclosures of intimate material that may trigger aggression when the violent partner feels aggrieved. At the same time, there is an urgent need to develop and evaluate treatment approaches to address the plight of young children whose parents have separated or divorced following domestic violence, who are in the physical and legal custody of both parents by order of the court, and who may continue to be exposed to violence in the home of one or both parents.

CTRP is in the process of developing and testing a treatment approach that aims at reducing the impact of ongoing domestic violence by working simultaneously with the perpetrator, the victimized parent, and the child in a variety of configurations that are chosen after extensive evaluation of each family member and of the family history. Treatment for the perpetrator is offered only when the results of the evaluation indicate that this parent is at least partially aware of the impact of the violence on his or her child and is willing to change the violent behavior. In this program, it has been found that if a decision to provide treatment involving a violent parent is reached, it is indispensable to conduct treatment under the aegis of explicit, preferably written guidelines that are agreed upon by the parent and that define safety both in the therapeutic setting and in the home as a prerequisite for treatment.

These safety guidelines are upheld through the following five concrete measures:

1. Formal involvement of the legal system, through the courts or child protective services, as overseers of the therapeutic contract with the violent parent.
2. The violent parent's legally mandated participation in an anger management or other relevant individual or group treatment program, with a release of information form signed by the violent parent authorizing exchanges between that program and the child therapist about the parent's participation and progress in each treatment modality.
3. A safe setting for conducting the treatment, including ready access to a security guard who can be called using an easily reached 'panic button' if the clinician feels the need for external support.
4. The violent parent's explicit and signed agreement to refrain from violent behavior during the sessions and to abide by agreed-upon behaviors when there is increased risk of violence in the home, such as going for a walk until it feels safe to return.
5. Signed releases of information where each parent allows the clinician to disclose to the other parent personal information that is relevant for the progress of treatment and wellbeing of the child.

These five measures help to provide a safe framework that enhances the potential effectiveness of treatment by modeling concrete protective actions for the child and the parents, and by increasing the therapist's sense of personal safety in conducting the treatment. The therapist's proactive stance in creating this safe framework represents for the child a symbolic rebuilding of the protective shield that was shattered by the domestic violence.

A shared component of both the CD-CP and CPP models is the use of supra-clinical intervention

modalities that bridge inter-systemic gaps. Just as the child's individual functioning cannot be shored up without attention to the parents' needs, therapeutic intervention can achieve only limited success unless embedded in a collaborative framework with the larger systems involved with parents and children exposed to violence. Harris, Putnam, and Fairbank (2005) emphasize the importance of becoming informed about and involved in partnerships with professionals, institutions, agencies, associations and government programs serving traumatized children and families at risk in order to improve access and quality of care. There is broad clinical consensus across theoretical orientations that involving the parents must be an integral component of best practice in the treatment of child trauma (Cohen et al., 1998).

However, in a substantial number of cases, the parents' own traumatization, psychiatric disturbances and/or substance abuse problems may interfere with their capacity to support or participate in their child's treatment. The lack of integration between the adult mental health system and the child mental health system makes it exceedingly difficult to coordinate treatment for the child and the parents. Services to children and adults are provided by different agencies with their own separate locations, policies, funding resources, eligibility requirements, fee structures, and clinical orientations.

When the parents and the child are traumatized by the same events, it is rare to find agencies that can address both parties' needs in a coordinated manner. The child clinician must strive to secure appropriate mental health or substance abuse intervention for the parents when their psychological functioning is so impaired that it affects the child's capacity to benefit from treatment. In this sense, clinicians working with traumatized children seldom have the luxury of focusing only on the child. Their work requires them to intervene to ameliorate the detrimental conditions in the child's toxic environment.

The detrimental effect of ongoing domestic violence is another obstacle to effective treatment. Whatever the therapeutic approach, when treatment is provided after the traumatic situation no longer exists, its goals involve two common components. The first involves placing the traumatic experience in perspective by helping the trauma survivor gain control over the overwhelming emotions evoked by the memory of the event. The second is the achievement of a differentiation between remembering and reliving, by stressing the difference between the past and present circumstances and increasing the survivor's awareness of the current, safer surroundings (Marmar, Foy, Kagan, & Pynoos, 1993).

When there is ongoing family violence, however, these goals are not realistic and may even be counterproductive, because hypervigilance and other

traumatic responses may be adaptive, though costly, mechanisms to increase personal safety. Attention to the conditions that increase safety and reduce risk must become the primary focus of the treatment in conditions of ongoing violence. Such a focus fosters progress towards another key goal in any treatment of trauma, namely, fostering an increased capacity to respond realistically to threat (Berkman et al., 2004; Marmar et al., 1993).

### *Clinical illustration*

The case of Andre described earlier demonstrates the futility of intervening too late with too few resources for a deeply troubled child in a toxic environment. In the next two cases, we provide examples of how the mental health service provider can collaborate with the police, courts, domestic violence advocates and child protective services while keeping in mind the specific goal of strengthening the child's and the family's mental health. Even in these cases, however, the outcome for the child is at best uncertain, if not pessimistic, because therapeutic intervention alone is insufficient relative to the basic needs of the children and their families.

### *The story of Sandra*

Sandra is a 23-year-old Latina woman with four children aged one to six years old. Sandra was threatened and beaten repeatedly by Juan, her boyfriend and father of her two youngest children. She did not report Juan's behavior to anyone. After a particularly serious incident, a neighbor called the police, but Juan had fled before officers arrived. Sandra told the responding officers some of what had happened that night but did not report the history of violence and stated that her children had not been home at the time. As part of the home visit project, one of the officers returned with a CD-CP advocate to talk with Sandra about her own and her children's safety and other needs. Sandra initially denied that she was afraid of Juan, but she later called the advocate to report another assault. Police attempted to arrest Juan for the new assault and for violating court orders to stay away from Sandra, but they could not find him despite Sandra's reports that she saw him frequently in her neighborhood. In frustration, officers concluded that Sandra was hiding Juan or warning him of their presence so that he would not be arrested.

Little by little, Sandra began to develop a relationship with the advocate and confided more of her fears for her current safety, her history of domestic abuse by her current boyfriend and by the father of her older children, and her own childhood neglect and longstanding feelings of loneliness, isolation and helplessness. As a child, Sandra had never known her father, had witnessed frequent abuse of her mother by multiple boyfriends and been exposed to

long periods of drug abuse by her mother. She had met the older children's father early in her teens and became pregnant at age fifteen. While Sandra remained dependent on her mother for financial assistance and child-care, she felt no love or emotional support from her mother or from anyone else. While terrified of Juan, she had many reasons for not wanting to align herself with the police or other authorities against him. On a practical level, she worried that he was too clever to be caught and believed that, even if he was arrested, he would soon be released and would come after her even more viciously for reporting on him. She believed his threats that he would kill her if she called the police and also worried that, alternatively, he would take the children or arrange for them to be removed by the Department of Children and Families (DCF) if she gave information against him.

With no meaningful job skills or employment history, unable to read and write and with four children to support, she depended on Juan's financial contributions to the family from his drug dealing. She felt she would be safer by staying on his 'good side,' or at least maintaining enough contact with him to monitor the tone in his voice and thus gauge his dangerousness from day to day. She had no reason to trust the criminal justice system to provide real protection from his physical attacks and threats and no reason to trust social service systems to help her maintain her family. These real barriers to help-seeking did not tell the whole story, however. At least as powerful were Sandra's wishes to reunite with her children's father in order to provide them with the two-parent family she never had, her hopes that he would stop abusing her, and her intense discomfort and sense of emptiness at being alone. While she feared her partner's violence, she had no confidence that she would be able to care for her children and herself without his help.

The advocate's first interventions were aimed at expanding Sandra's sense that there were options available to her other than passively tolerating Juan's behavior and sending her children to her mother from time to time. The advocate introduced Sandra to the police officers in her neighborhood and, together with the officers, provided Sandra with information about resources to increase her safety and contain Juan's aggression. For example, the advocate obtained a 911-programmed cell phone for Sandra so that she would be able to contact police from any location. Sandra couldn't say for sure if she would use the cell phone, but she reported feeling safer knowing it was in her pocket. After she received the phone, she also seemed to answer the door more consistently when the police-advocate team visited, which the team took to indicate greater trust, perhaps in response to seeing that the team took her and her situation seriously. The advocate encouraged Sandra to report Juan's behavior and whereabouts to the police, but left the decision in her hands.

As Sandra made sporadic efforts to work with the police to arrest Juan, the advocate began to help her pay closer attention to her children's reactions to the instability and violence in their environment. In beginning to address the children's needs, the advocate emphasized that she recognized how much Sandra cared for her children and understood how hard it was for her to see that her children really were having difficulties. The advocate knew how worried Sandra was that others would think she was not a good mother and would report her to DCF and take her children. Thanks to support from clinicians on our team, the advocate also understood that Sandra's fear of external condemnation and removal of her children also represented a defense against her own worries that she was inadequate to parent her many young children in the context of such adversity.

The advocate arranged a series of home visits and office appointments with a clinician experienced in evaluating young children to provide information and recommendations to Sandra about her children's needs. The team found the home chaotic and disorganized. All of the children appeared developmentally delayed to some degree. Sandra provided little effective limit setting. She remained passive as her two-year-old son hit and grabbed toys from his sisters. She rarely engaged the children in reading, play or conversation but sat withdrawn watching television or talking with the advocate about crises in her life.

The evaluating clinician was most concerned about Theresa, a 4½-year-old girl still in diapers, with a pacifier in her mouth during much of the time, using very little language and persistently aggressive with her mother and siblings. The clinician conducted a brief developmental screen in the home and urged Sandra to bring her daughter to the clinic for a more complete assessment. The team talked with Sandra about the importance of reducing the violence and disruption the children experienced. They also began working gently with her to implement a behavior plan for toilet training Theresa, with the goal of enrolling her in a preschool program. The team reasoned that a preschool program would provide the toddler with age-appropriate structure and stimulation and would simultaneously lessen the burdens on her overwhelmed mother.

The advocate also tried to introduce the idea of a mental health evaluation and treatment for Sandra herself, to help her understand her symptoms better and to treat her significant depression. While Sandra was appreciative of the team's efforts to understand her children and agreed that it would be good for her daughter to be able to attend a preschool, she rejected the idea of seeing a clinician for herself, stating that she would be fine if only she could find a new apartment. As Sandra responded to a never-ending series of family and financial crises, she became more disorganized and did not participate in

any of the team's recommended interventions. She attended only a few clinic appointments and failed to answer the door when neighborhood officers stopped to check on the family. A neighbor reported yet another domestic assault to the police, and this time officers filed a report with DCF, based on their concern that Sandra was unable to protect her children from continual exposure to violence.

Though by this time Sandra had lost contact with the advocate, she immediately called her when she became aware of the DCF referral. The advocate reminded Sandra of the recommendations she and the clinician had made several months earlier. In response, Sandra agreed to have the advocate work together with DCF to help develop a plan to increase the family's safety and to meet the children's developmental needs. Recognizing the children's developmental delay, DCF required Sandra to maintain regular attendance at clinical appointments, with the goal of completing developmental assessments for all of the children and engaging them in appropriate preschool programs. DCF also emphasized to Sandra the ongoing danger presented by Juan. Rather than just demanding that Sandra get a court order or go to a shelter, the DCF worker worked with Sandra, the CD-CP advocate and police to see that he was arrested on outstanding warrants and to develop a plan for establishing a safer residence. After Juan's release on bond, police continued to visit the area to monitor his compliance with a court order to stay away from Sandra pending disposition of his criminal cases.

The DCF worker also made frequent home visits and assumed the burden of reporting Juan's presence, so that Sandra would not have to be responsible for turning him in and subjecting herself to retaliation. By their combined efforts, the team was showing Sandra that she did have options and that she was not helpless and alone. With the clear limit set by the court and DCF that Juan could not live in the family home, and with an array of others supporting her, Sandra felt more confident in refusing him entry into the house.

The team reiterated the recommendation that Sandra become involved in therapy for herself to lessen her continued depression. Now, with child protective services monitoring her compliance with clinical recommendations, she did not refuse outright, but she had little interest in actively pursuing an adult mental health contact.

In the end, the combination of practical and psychological barriers to this intervention proved insurmountable. There was no adult mental health clinic with a Spanish-speaking therapist available that would take her state insurance. She had no transportation and no one to care for her children while she attended clinic appointments. In addition, the idea of mental health treatment felt alien and frightening for Sandra, who had spent her entire life dealing with a mountain of external problems and

who conceptualized all of her difficulties as caused either by other people's abuse or by fate. While we could never be certain, the team speculated that Sandra feared that seeing a psychiatrist would confirm that she was crazy or inadequate and would lead to removal of her children.

Following the child protective services referral, Sandra became more reliable in her clinic attendance, completed the children's evaluations and accepted the clinician's help to enroll Theresa in a special needs preschool that did not require independent toileting. The team also helped Sandra to obtain school-based speech and language services for her six-year-old. As the clinician began to turn her attention to Sandra's relationship with her highly aggressive two-year-old son and to support her to set more realistic and effective limits, Sandra again stopped attending her appointments. She explained to the advocate that she needed to move her family closer to her mother, where she could get help with child care and be farther away from Juan. When last in contact with our team, Sandra remained significantly depressed and her children, while having received help in important areas of their development, remained at risk. However, there had been no further assaults or threats by Juan in many months, the family had experienced a more positive connection than ever before with clinicians and developmentally informed supports, and the CD-CP collaboration with child protective services had established a foundation for continued monitoring and referral to new services.

This case demonstrates both the difficulty of effectively intervening to support children whose development has been disrupted by serious violence and adversity and the potential for at least some small successes. Here, Sandra began with a hopeless and defeated view of the world and herself as a mother, based in her repeated experience of neglect and abuse. The CD-CP team made some headway in interrupting the continual domestic abuse by coordinating with criminal justice and child protection systems to provide authoritative limit setting and containment of Juan, while at the same time developing a supportive relationship with Sandra centered on recognition of her role as a mother and her wish to provide her children with better parenting than she had received as a child. For Sandra, too, it was important to have child protective services set firm requirements and limits so that she would remain engaged in the difficult work of attending to her children's complex needs.

This family illustrates that modest progress is often the most that mental health services can accomplish in the absence of far-reaching social changes to provide a safety net for the family consisting of adequate housing, safe neighborhoods, comprehensive health care, basic education, opportunities for job training and job placement, transportation, and affordable and reliable childcare. In

the absence of a real and accessible family support system, the intertwined contributions of individual and system dysfunction become impossible to disentangle.

While the above case illustrates extensive attempts to work with the mother as the focus of the intervention, the next case demonstrates the potential of focusing on the parent-child relationship as the focal vehicle of the intervention.

### *The story of Armando*

Armando was 3.9 years old when he and his parents, Mr. and Mrs. Lopez, were referred for Child-Parent Psychotherapy(CPP) at the Child Trauma Research Project (CTRP) by family court due to a bitter child custody dispute between the parents. The parents had been married for 10 years before the mother decided to divorce as the result of domestic violence. The court had granted the parents joint physical and legal custody of Armando, but mandated treatment because of ongoing concerns about domestic violence.

CTRP has a standing agreement with the court that the program will only provide intervention if we believe that the family can benefit from treatment and if the parents voluntarily agree to it. The court referral included graphic descriptions of Mr. Lopez's violence against his wife and of his anger at her decision to divorce him. His volatility raised concerns about the wisdom of seeing him in the same clinical setting as his wife because of the possibility of his stalking or attacking Mrs. Lopez, the clinician, or both if he became dissatisfied with the treatment. To maximize safety, we obtained permission from the judge to conduct the sessions with Mr. Lopez in an office located in the court building. Mr. Lopez agreed with this arrangement.

In telephone conversations, the clinician made separate appointments with Mr. and Mrs. Lopez to describe the assessment, the CPP format, and the requirements described earlier about the releases of information and commitment to refrain from violence. The clinician also stressed the voluntary nature of treatment.

During the assessment, Mrs. Lopez described a long history of domestic violence that included rape, beatings, a near-choking episode, and verbal threats and insults and that had started soon after the marriage, continued during her pregnancy with Armando, and was witnessed by the child. Mr. Lopez, for his part, denied the intensity of the violence and said that both he and his wife were 'hot blooded' and yelled and pushed each other when angry. He said that his former wife was 'crazy' and was 'making Armando crazy'.

Both parents were immigrants from a country that had been engulfed in civil war while they were growing up, and both of them had witnessed atrocities (including shootings at close range) from an

early age in the rural villages they hailed from. Both parents had also been subjected to harsh physical punishment by their parents. Mrs. Lopez reported two episodes that were particularly brutal, one in which her mother pushed her into an open fire for allegedly 'flirting indecently' when she was fifteen years old, and another episode in which her father hit her with a frying pan over the head and rendered her unconscious when she answered him back during an argument. The assessments revealed that both parents suffered from post-traumatic stress disorder (PTSD). In spite of these difficult circumstances, both parents held steady jobs, although they both received the minimal wage and often had difficulty making ends meet.

The assessment of Armando revealed that the child was simultaneously very aggressive and in a permanent state of fear. On different occasions he had chipped his mother's front tooth by hitting her with his head while she was trying to control him during a tantrum, bruised her rib cage, scratched her face, and told her that she was 'crazy.' The pre-school teacher reported that he had difficulty tolerating frustration and that he bit, hit and kicked his peers when they did not share a toy or include him in their play. His feelings were easily hurt. He often whispered, 'Nobody loves me' in response to a disciplinary action. Armando suffered deeply from his father's absence from the home, and on one occasion woke up crying at night and yelled, 'Papa Dios, take me because my daddy is not here.' While over-estimating danger, he had acquired a precocious ability to protect himself. When a woman he did not know chastised him in a store for hitting his mother, he walked up to the cashier and said, 'Call the police. That woman is being mean to me.'

Armando also tried to defend himself by taking aggressive action. During the first assessment session, he told the clinician he did not want to be there and added, 'I'm going to ask my father to come kill you because you're stupid and to kill my mom too because she brought me here.' He was easily startled by unexpected noises and had intense separation anxiety from both his mother and his father, crying inconsolably when moving from one parent's home to the other. Like his parents, he met criteria for PTSD.

The treatment format involved one weekly child-mother session and one weekly child-father session with the same clinician. The clinician also recommended individual psychotherapy in a community mental health clinic for Mrs. Lopez to address the long-term sequelae of her childhood abuse as well as the lingering effects of the domestic violence. Mr. Lopez had already started a year-long anger management class.

The sessions with Armando and his mother took place in a program playroom, while the session with Armando and his father took place at the office located in the court, which was furnished with the same toys that Armando played with at CTRP. Both

parents attended treatment regularly. Approximately three months after the beginning of treatment, the clinician had to make a referral to child protective services because Armando had a bruise and scratches on his arm when he arrived for a session with his mother. When asked about the bruise and the scratches, he said, 'My daddy threw me on the ground because I ran away.' Mrs. Lopez confirmed that she had noticed the bruises after Armando had spent the weekend with his father. Little by little, Armando revealed that he and his father had gone to the beach and that he had become angry at his father because he did not want to leave. Armando threw a stone at his father and ran away. His father had run after him, thrown him on the sand and held him down while yelling at him.

After Armando and his mother left the session, the clinician phoned Mr. Lopez to discuss the incident. Mr. Lopez readily agreed with Armando's description, and said he was sorry for losing his temper with the child. The clinician then explained that she had a legal obligation to make a report to child protective services. Mr. Lopez became very angry, telling the clinician that she was over-reacting and saying that he could never trust her again. The clinician answered that the work they were doing together focused on helping Mr. Lopez not hurt or frighten his child, and that the episode on the beach indicated that extra help was needed to make that happen. Mr. Lopez replied heatedly that he was already going to his anger management class and that he didn't know what else he could do. The clinician assured him that she would continue to be available to him and that she would speak to the child welfare worker about the efforts Mr. Lopez was making. She then proposed meeting for an individual session the next day, after the clinician made the report to CPS, to discuss the events and plan how to talk to Armando about what had happened on the beach.

The referral to CPS led to an unexpected turn in the treatment because, to the clinician's chagrin, the child welfare worker demanded that Mr. and Mrs. Lopez participate in marital therapy, despite their being divorced, as a condition for not bringing the case to dependency court. Mrs. Lopez refused, and Mr. Lopez was frantic because he worried that he would lose his access to his child. The clinician then requested a Team Decision Meeting (TDM), an innovative vehicle to facilitate dialogue in which parents can bring advocates of their choice to meet with the child welfare worker and a facilitator appointed by CPS. Prior to the meeting, the CTRP clinician discussed the situation with Mr. Lopez's anger management class coordinator and they developed a shared action plan to present at the TDM.

The TDM was attended by both parents, the child welfare worker, the CTRP clinician, Mr. Lopez's anger management class coordinator, and Mrs. Lopez's individual therapist. The mood was tense and it was clear that Mr. Lopez was very angry at the CTRP

clinician for, in his view, precipitating this course of events. Nevertheless, the results of the meeting were fruitful. The child welfare worker relented in his insistence that both parents attend marital therapy. Instead, it was agreed that Mr. Lopez would attend individual anger management sessions to supplement the group classes he was already attending. The schedule of CPP sessions would remain unchanged. This arrangement had been discussed in advance between the CTRP clinician and the anger class management coordinator, who had presented it to Mr. Lopez prior to the TDM. Mr. Lopez had reluctantly accepted the proposal because he understood that his behavior towards Armando at the beach had revealed the extent to which he could lose control of himself when overcome by anger.

Six months later, the child welfare worker closed the case because Mr. Lopez had successfully completed the family maintenance requirements. The CTRP clinician was concerned that Mr. Lopez would take advantage of this opportunity to stop attending Child-Parent Psychotherapy with his son, but was relieved to find that this was not the case. The pleasurable moments and the increase in warmth and intimacy that Mr. Lopez and his son were able to build through these sessions were an incentive to the continuation of treatment.

As Mr. Lopez showed a decrease in emotional volatility in his relationship with his son and his attitude towards Mrs. Lopez, the clinician suggested a session where both parents would meet with her to discuss their child's progress and ongoing needs. During this meeting, the clinician helped the parents differentiate between their mutual resentments towards each other and their joint commitment to their child. This session was followed by several others, and culminated in three joint sessions involving Armando and his parents prior to the termination of treatment. In these sessions, the clinician helped to articulate the sadness that all the family members felt about the breakup of the family, and enabled the parents to assure Armando of their joint commitment to him. It was notable that Mr. and Mrs. Lopez took Armando to a street fair together prior to the last treatment session, and reported later that all had gone well among them. This collaboration on behalf of their child bodes well for the future. However, the parents' history of severe trauma constitutes an ongoing set of risk factors that call for cautious optimism at best in predicting Armando's developmental course.

This case example highlights the clinical usefulness of coordinating mental health services with child protective services and with the court. The level of violence in the lives of Mr. and Mrs. Lopez declined considerably as the result of treatment, and Armando's behavior improved dramatically as the result. By the end of two years of treatment, he no longer met criteria for PTSD and was successfully attending kindergarten at a private school with a full

scholarship. When he was 8 years old, his mother called the CTRP clinician to tell her that a painting by Armando had been selected by his school for an exhibit at a children's museum. It is difficult to believe that this would have happened had the judge not ordered this family into treatment, and had there not been a productive collaboration among the different service systems involved when the referral to CPS was made. This is one example of the emerging models of court-mental health system collaboration that transcend the traditional boundaries between the legal and mental health system, all with the purpose of serving traumatized children (Lederman & Osofsky, 2004).

### Examining individual cases through the ACE's lens

Let us now look at the three cases described above through the lens of the ACE studies (Felitti et al., 1998). In the case of Andre, we see that the odds were stacked against him even before the clinician met him in the hospital, because he was raised in an environment in which he endured every one of the nine adverse childhood experiences identified in the ACE study: violence against his mother, psychological and physical abuse, psychological and physical neglect, absence of a parent, living with household members who were substance abusers, mentally ill, or ever imprisoned. This tragic case illustrates the compounded effect of these risk factors in his own self-destructive behavior, which had endangered his life and the lives of others.

The case study of Sandra also illustrates the enormous challenges each of her children will face as they grow up. Sandra's children shared a mother who had at least five adverse childhood experiences: physical abuse, witnessing domestic violence, a mother who had substance abuse and was mentally ill, and an absent father. The children themselves, in spite of their young age, were already presenting with difficulties associated with these adverse childhood experiences. Here we see the intergenerational effect playing out from parent to child.

Even though Armando is being raised in a more economically stable environment, he will also face daunting challenges. Armando has witnessed the violence inflicted by his father on his mother and both parents have a mental illness in the form of PTSD. His father has a drinking problem that he denies. His mother has a long history of physical and emotional abuse and was raised by a single mother after being abandoned by her father. While we can be hopeful that Armando and his parents might appear to be helped by the therapy, the ACE study would suggest that Armando remains substantially at risk for long-term difficulties.

Felitti et al. (1998) point out that in addition to the mental health challenges of childhood adversity,

these children are also at risk for negative physical health sequelae. The mediating factors between early trauma and adult illness often involve health-risk behaviors. It is important to note in each of these cases that these adverse conditions are chronic, while the mental health services available are time-limited due to financial and regulatory constraints. This mismatch between chronic environmental stressors and enduring psychological problems on one hand and treatment modalities best suited for acute conditions on the other hand is often unrecognized as a primary reason for the failure of mental health interventions to promote meaningful change.

A therapist alone cannot undo the impact of chronic environmental insults. A host of additional supports must also be available for these children and families, and the provision of these services, ranging from housing and job training to childcare, is expensive. Furthermore, there are often long waiting lists and bureaucratic barriers to accessing these services.

### Acknowledging failure: can we respond effectively?

Failure is a powerful word. Can it be fairly used to describe our responses to child trauma in the U.S. today? We believe it can.

If we believe there is a social responsibility to prevent more 'Andres,' we have not done so effectively. If we believe that 'Andres' cannot be prevented, can we acknowledge that we should at least be able to identify children such as Andre and their circumstances earlier, diagnose them, and make an effort that is commensurate with our scientific and theoretical knowledge to relieve their pain? We think so. Even if this notion is considered utopian, do we have a justification for giving up on this goal or providing less effort? We are not aware of one, nor can we accept one.

We know there are millions of children in the U.S. who have endured traumatic events and continue to live under horrendous circumstances and yet have been neither identified nor helped. We know that 'bad luck' or idiosyncratic events can account for many acute traumatic events. But we also know that chronic, repeated traumatizations are still the rule for millions of children and families, and that their causes, though often complex, are well known.

How then can we explain the chasm between what we know about the enormity *and* the severity of the child trauma problem versus what we as a society do about it?

Any one of the factors identified by Felitti et al. (1998) has the potential to overwhelm a mother's capacity to cope, particularly in conditions of poverty. If she has endured several adverse childhood experiences, how can we expect her to marshal her internal resources to provide a consistent, caring,

loving environment to her children? If she can't or doesn't, should we be greatly surprised by her child's difficulties in day care, school, the neighborhood, and so on?

And what about society's response to the needs indicated to help this mother – ample day care, affordable food and shelter, and living-wage jobs? How can mental health professionals, too often operating from within their own isolated silos, provide sufficient relief to these children and families in these difficult environmental circumstances, without the supportive services required to sustain their clients?

Even if police departments have been provided with rigorous, 'trauma-focused' training similar to the New Haven CD-CP program, how can they operate effectively when their ranks are being reduced, after-school program funds are being cut, and schools are failing and continue to be underfunded? Furthermore, the other service providers with whom trauma victims interact are rarely as well-equipped with this trauma-informed lens as police officers who are trained in understanding and responding to developmental trauma.

We who try to connect these known and well-understood 'dots' to explain the interconnections among the social supports provided to people and providers (or lack thereof) run around in circles advocating, cajoling, pleading with policy makers to stop, look, listen and act accordingly, but to little or no avail.

We know there is competition for resources among those who are engaged in helping traumatized children and their families. The child protective system needs more resources. Head Start teachers don't make a living wage. The juvenile probation system is woefully under-resourced. The list goes on and on. When one system is fighting for its own silo's resources, can we really expect it to fight on behalf of other systems that are competing for the same resources at the same time?

### **Self-interest**

Focusing the trauma lens and applying our empathy to the plight of battered women, we can understand how few emotional resources may be available to help them care for themselves and their children. We can also begin to understand how the same women may be immobilized by terror, anxiety and depression, and that some may turn to drugs or alcohol in an effort to cope (Felitti et al., 1998). While we may see any of these responses as operating against a mother's self-interest, she may not be able to share our perspective.

Similarly, we can understand the frustration of police administrators who wonder if it is in their organization's self-interest – or even if it is possible – to respond more effectively to increased community

demands for support services when their own budgets are being cut and forces reduced. We might also be able to appreciate why judges feel so limited in their role as social change agents, when options for care, intervention or treatment for families who appear in their courtrooms are so few. We can better understand why an overburdened teacher may lash out verbally at a misbehaving pupil or at angry parents who blame the teacher for their child's poor school performance.

As resources from federal, state and local governments are cut in so many areas where traumatized children and families live out their lives, there are increasing pressures for parents to retreat into themselves and for service agencies to stay within their own protective silos. This may appear to be the only recourse available to them. Selfish impulses are both natural and destructive. They are the origin of the self-perpetuating failures we are witnessing in our social service systems today. As we go to government to better our respective silos and our own positions – in the academy, in the village, in the military, wherever – obtaining resources often turns out to be a zero sum exercise. In these times of limited funds, any winner of more resources causes another provider to become a loser.

Give me mine. I need it more.

More cops, not teachers.

More military hardware, not research funds.

More social workers, not arts programs.

Garett Hardin, in a brilliant essay in *Science* (1968), tells the story of the 'tragedy of the commons.' A small village had enough grass to feed each villager's cow. But one day one person bought two cows and fed them on the commons. The neighbors soon followed suit until the common grass was all gone. The field became unsustainable and all the cows starved to death; thus, the tragedy of the commons.

### **Government policy**

How then can we synthesize our knowledge about the scale of the problems related to traumatized children and families and the recognition of the adverse consequences that will surely follow if the problems remain unaddressed? We know we must connect the dots among many service providers to offer a more effective web of support for these children and families. We also know that only when these different sectors are adequately funded can they fulfill their promise and their missions, and only then can we hope for them to coordinate their activities and implement an integrated public policy.

Both CD-CP/NCCEV and CTRP are actively involved in two federally-funded initiatives to foster collaborative interventions on behalf of children and families traumatized by violence. The National Child Traumatic Stress Network, funded by the Center for

Mental Health Services (CMHS) of the Substance Mental Health and Service Administration (SAMHSA), comprises more than forty centers across the country and has the mission of increasing access to treatment and enhancing the quality of care for traumatized children and their families. The Safe Start/Promising Practices Initiative is funded by the Office of Juvenile Justice and Delinquency Prevention of the United States Department of Justice to foster collaboration and service integration among government entities, the legal system, and community agencies on behalf of children under six years of age exposed to violence. Participation in these and other collaborations enables CD-CP and CTRP to extend their reach by providing cross-training, implementing inter-system models, and working cooperatively with law enforcement, the courts, the child protection system, battered women's shelters, and community and social service agencies.

Nevertheless, the National Child Traumatic Stress Network has shrunk from more than fifty participating sites to just over forty. Qualified programs were recently removed from the Network in an effort to make funding available to new qualified sites. The Safe Start Initiative under the Department of Justice has 20-odd sites in the entire country, and questions remain about continued federal support and long-term sustainability.

Time and time again we have failed to take successful programs to scale. Demonstrated best practices receive awards, commendations, and media praise, but remain under-resourced, precariously funded, and unreplicated in wider settings. Sometimes, they are eliminated altogether.

As if failing to take successful programs to scale were not bad policy enough, recent budget cuts proposed by the President's 2007 budget certainly make a dire situation even worse. The President's 2007 budget calls for cuts in education, housing, and a host of other programs that provide crucial help to our neediest families. While some of these program cuts may be restored, Congress will certainly not be able to expand these vital programs to meet the needs of the millions of children and families still underserved, if indeed served at all.

It is indeed ironic that just as the field has begun to acknowledge evidence-based treatments for traumatized children and families, the basic services that are needed to sustain these children and families continue to be woefully under-funded. There are a number of childhood trauma treatments with empirical evidence of efficacy, including treatments for different types of trauma, such as sexual abuse (Cohen, Deblinger, Mannarino, & Steer, 2004), traumatic grief (Cohen, Mannarino, & Deblinger, 2006), domestic violence (Lieberman, Van Horn, & Ghosh Ippen, 2005) and community violence (Stein et al., 2003; Marans, Murphy, Casey, Berkowitz, & Berkman, 2006). In randomized controlled studies, traumatized children treated with these therapeutic

modalities have demonstrated statistically significant reductions in symptoms and improvements in functioning when compared to children treated with other interventions. In spite of this evidence of success, none of these interventions has been brought to scale and made available to even a fraction of the children who could benefit from them. Similarly, with substantial cuts in federal research and program evaluation funds, many promising practices that are based on supra-clinical approaches to children and families traumatized by violence will remain at best local efforts or simply wither on the vine.

### **In the best interests of society: a public education approach**

What then will it take to create a better future for traumatized children and their families? We believe it will take a massive infusion of billions – not millions – of new and reprogrammed government dollars so that we can intelligently apply what we know and can do effectively to help these children and families and prevent new generations from facing the same difficulties.

To secure these new funds, we will have to compete in the democratic marketplace of new ideas with other worthy causes and entities that are pursuing the same scarce government resources.

To win, a massive, determined, and ongoing public education effort must begin to bring to the public's attention the sheer enormity of the problem and the social costs of failure. At the same time, we must make clear that we can intervene effectively and prevent new cases. If we present our case well, the public will begin to understand it is in society's best interests to command and redirect these resources toward a better outcome for traumatized children and families.

Designating childhood trauma a public health issue will be helpful in calling public attention to the problem. But it will only be one step. Monetizing the true costs of the problem to society will also be required. A careful and encompassing study of the true social costs of childhood trauma will attract the attention of business leaders and the media, which in turn will attract the attention of elected officials. The expertise of the Government Accountability Office and the Congressional Research Service should prove invaluable to this task.

An additional approach would be the creation of a national commission to study and report back to Congress and the Executive Branch on the subject. A cautionary note, however...

All too often, special commissions – whether presidential or congressional – produce impressive summaries and recommendations for action, are heralded in the media, then pushed aside in favor of other urgent priorities. Libraries, universities, state

houses and governmental offices are strewn with the detritus of these commissions.

There has been a call for a Presidential Commission (Harris et al., 2005) on the subject of childhood trauma. There have also been attempts to initiate a similar kind of activity at the state legislative level. But in the end, a successful public education effort will require not just fact-finding commissions, but broad and committed leadership that unites the best of our science and experience, with the passion to fight for the required resources needed to help our traumatized children and families.

### The example of Paul Farmer

Where can we find a model of this kind of leadership? We suggest one example: Dr. Paul Farmer, Professor of Medical Anthropology at Harvard Medical School and Founding Director of Partners in Health.

In the face of incredible obstacles, Dr. Farmer started Partners in Health to address the pandemic health problems in Haiti and other locations of extreme poverty (Farmer, 2005; Kidder, 2003). He began by assessing the 'reality' of tuberculosis, HIV/AIDS and other chronic, life-threatening illnesses in impoverished communities. While realistically assessing the massive challenges he encountered, he simply refused to accept the notion that 'we can't do better.' He forged ahead undaunted and changed many of the realities he faced as he developed new sources of support and local systems of care for thousands, perhaps millions, of desperately poor and sick people from Haiti to Peru to Siberia to Rwanda to the United States. His efforts have been lauded around the world.

Farmer, his colleagues, and others who share his vision are challenging our conceptions of what is acceptable, and leading, by extraordinary example, a global change in the way health care is provided to the poor.

We believe that as a country, we must approach the problem of childhood trauma in the U.S. with the same energy, intelligence and commitment that Farmer and his colleagues have applied to the pandemics of HIV/AIDS and TB. We too must refuse to accept that 'we can't do better.'

It has often been said that crises can either be overwhelming and traumatic or can provide opportunities for change and growth. As we face the public health crisis of childhood trauma, we must decide in favor of growth. And, if we are to change the trajectory and cumulative impact of our children's unattended exposure to overwhelming events, we simply must forge ahead.

This nation urgently needs to find people who will stand up and say – in the media, classrooms, and the political arena – 'We can no longer pretend that saving one child at a time is enough. While we must continue to believe that helping that one child and

his or her family matters, we can no longer remain silent and ignore the millions of children and families whom we are not serving.'

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